Evidens

Hamid Mohseni

Physical therapists within the psychiatric field

Creating alliances with depressed patients

Sjukgymnaster inom psykiatrin

Skapandet av allianser med deprimerade patienter

Examensarbete för Psykoterapeutprogrammet
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Sammanfattning

Uppsatsen undersöker hur sjukgymnaster hanterar mötet med patienter med diagnosen depression för att uppnå ett optimalt samarbete. Intervjuer användes för att samla data ifrån tre sjukgymnaster på en psykiatrisk avdelning och ett fenomenologiskt och hermeneutiskt perspektiv användes för att komma fram till kärninnehållet i deras åsikter om samarbetet med patienten. Alla tre sjukgymnaster ansåg att omsorg och empati bekräftar den psykiskt sjuke patienten i försöken att må bättre och uttrycker samtidigt en respekt för patientens autonomi. Respondenterna ansåg att patienterna skall få information om sitt tillstånd och sin behandling som är så formulerad att han eller hon kan ta till sig detta. Vikten av en gemensam behandlingsplan betonades. Eftersom svår depression ofta bär med sig nedsatt kognition är det extra viktigt att patienten blir väl bemött av vårdpersonalen och att de tar med patienten i beslutsprocessen så att han eller hon motiveras att delta. Omsorgen är närande. Den är grundad i altruismen som har beskrivits av ”det biologiska behovet att hjälpa”. Fem viktiga delar av omsorg och vård är kommunikation, empati, respekt, information och individens egna mål. Uppsatsen argumenterar att omsorg är viktigare än empati, att empati borde omdefinieras så att den inte bara innebär att man vet vad patienten känner utan att man därmed investerar i patienten känslomässigt och motiveras att hjälpa. En viktig slutsats är att samverkan med patienten är nödvändig och att respekt för individens egna mål är av stor hjälp för den psykiatriska patienten som ofta är synnerligen utsatt i och med att självaktning ofta saknas.

Keywords: Omsorg, allians, depression, bemötande, fenomenologi.

Abstract

This paper examines how therapists handle interactions with patients diagnosed with depression in order to achieve optimal cooperation. Interviews were used to collect data from three physiotherapists in a hospital's psychiatric department, and a phenomenological and hermeneutical perspective was used to reach the core content of their opinions on cooperation with the patient. All three physiotherapists believe that caring and empathy confirms the mentally ill patient in her/his attempts to recover. They also believed in respect for the patient's autonomy and a belief that she or he should receive information about her/his condition and its treatment and that this information should be so formulated that she or he can take this on. The importance of a common treatment plan was stressed. It is essential that health professionals are aware of the cognitive impairment depression often causes and treat the patient based on this knowledge. This increases the patient's motivation to participate in her/his own treatment. key areas are concern and care, communication, empathy, respect, information and the individual's own goals. The essay argues that care is more important than empathy, “empathy” should be redefined so that it not only means that one knows what the patient feels but also that one makes an emotional investment in the patient and is motivated to help. An important conclusion is that interaction with the patient is necessary and respect for his or her own goals is beneficial for psychiatric patients who are often extremely vulnerable in that they lack self-esteem.

Keywords: Caring, alliance, depression, encounter, phenomenology.

Resumé på svenska

Uppsatsen börjar med att ge en kort beskrivning av åkomman depression och dess utveckling, från Hippokrates tid till nuet. Depression har varit ett välkänt fenomen redan under antika Grekland och ingår idag i DSM-systemet. Olika psykologiska inriktningar och deras mest typiska förklaringsmodeller om depression beskrivs kort i inledningen. Det psykodynamiska perspektivet anser att individer som har fått en ojämn mängd av kärlek i sin barndom löper stor risk för att utveckla depression. Freud menar att roten till depression är förlusten av något/någon man älskar. Förlusten kan både vara verklig eller bara i fantasin. Enligt det biologiska perspektivet ligger den främsta orsaken till depression i obalans i hormoner i hjärnan. Det sociala perspektivet söker orsaken till depression mer i den sociala miljön individen har växt i. Enligt det ökar risken för depression om individen har varit utsatt för hög grad av stress genom sina levnadsår. Det kognitiva perspektivet anger dysfunktionella tankar och en skev världsbild som främsta orsaker till depression.

Den deprimerade känner ofta en förlust av energi och trötthet. Uppgifter som tidigare har varit en naturlig del av vardagen nu verkar vara omöjliga att hantera. Uppsatsen beskriver vidare att sjukgymnastrollen inom psykiatrisk vård har på senare tid uppmärksammats på allvar. Detta till stor del tack vare många studier som har visat på många positiva samband mellan fysisk aktivitet och lindring av depressionssymptom. Sjukgymnaster inom psykiatrin använder sig av bl. a basal kroppskännedom som går ut på att med enkla meditativa rörelser aktivera den deprimerade och därmed minska muskulär spänning samt minska risken för metabola syndrom. Uppsatsen belyser problemet med alltför många avbokningar bland deprimerade som många sjukgymnaster inom psykiatrin upplever som ett påfrestande moment. Bland annat nämns en longitudinell studie gjord av Norcross (2002) där han följde upp 74 deprimerade patienter och deras vårdkontakter. Studien visade att samtliga patienter hade större antal avbokningar hos sjukgymnaster och arbetsterapeuter jämfört med hos psykologer, sjuksköterskor samt läkare. I den aktuella uppsatsen dras slutsatsen att detta beror på avsaknaden av den fysiska energin som krävs i mötet med framförallt sjukgymnaster.

Syftet med studien var att ta reda på hur tre sjukgymnaster inom psykiatrin gör för att etablera allians med sina deprimerade patienter. Det finns en uppsats skriven vid avdelningen för sjukgymnastik på Luleå tekniska universitet med en snarlik titel, ”Hur bör sjukgymnaster inom psykiatrin bemöta patienter med ångestproblematik för att nå en så god allians som möjligt”.

Denna studie vill undersöka hur sjukgymnaster gör för att etablera allians med deprimerade patienter som till skillnad från patienter med ångest har ingen eller mindre energi, motivation samt vakenhetsgrad. Studien började med att samtliga sjukgymnaster inom psykiatrin verksamma på Mölndals sjukhus kontaktades. Antalet psykiatrianställda sjukgymnaster där är begränsat till 4 kvinnliga sjukgymnaster i åldrarna 35 - 64 år. En av dem var på mammaledighet. Samtliga 3 andra sjukgymnasterna lämnade sitt samtycke till att medverka i studien.

Efter att ha informerat dem om studiens syfte både skriftligt och muntligt planerades platsen där intervjuerna skulle äga rum. Varje intervju tog mellan 50-60 minuter och materialet transkriberades och analyserades enligt Giorgios metod som är en deskriptiv fenomenologisk metod (Giorgi 2009). Fenomenologin fokuserar på människans medvetande och upplevda erfarenheter. Undersökaren anstränger sig för att få individen att formulera dessa erfarenheter i ord. Det fordrar därför att undersökaren fördjupar sig i informatörens livsvärld och lyckas få denne att avspegla sin upplevelse. Den deskriptiva fenomenologin karaktäriseras av den fenomenologiska reduktionen. Detta betyder att undersökaren frigör sig från sina förutfattade meningar och enbart redogör fenomenet så som det uppvisar sig för undersökarens medvetande. Som undersökare bör man vidhålla ett kritiskt förhållningssätt för de egna beskrivningarna av fenomenet och därmed förhindra att dessa går utöver insamlad data. Huvudmålet med undersökningen är att få fram essensen av fenomenet vilket är kärnan av det vi undersöker.

Analysen av insamlad data skedde i fyra steg. I första steget skrevs alla inspelade intervjuer ner ordagrant och lästes igenom i flera omgångar. Detta i syfte att få ett helhetsperspektiv. I andra steget identifierades meningsbärande enheter (så kallade MU) som plockades ut. I tredje steget analyserar man de meningsbärande enheterna med fenomenet i beaktande och sammanför dem till inbördeskategorier. Inbördeskategorierna förtydligar variationen i det analyserade materialet. I steg fyra försöker man finna en gemensam nämnare i alla kategorier. Om man finner något är detta essensen av fenomenet.

Alla tre sjukgymnaster ansåg att omsorg och empati är det som bekräftar den psykiskt sjuke patienten i dennes försök att må bättre. Dessutom så uttrycker sig denna omsorg i en respekt för patientens autonomi och en uppfattning att man ska få information om sitt tillstånd och sin behandling som är så formulerad att patienten kan ta till sig informationen. Vikten av en gemensam behandlingsplan betonades, och detta passar det fenomenologiska perspektivet som

betonar människans plats i en livsvärld där individen ständigt riktas mot framtiden genom de utkast som görs av det som finns tillgängligt.

Eftersom svår depression ofta bär med sig nedsatt kognition är det viktigt att patienten blir väl bemött av vårdpersonalen och tas med i beslutsprocessen för att på så vis motiveras att delta. Omsorgen är närande. Den är grundad i altruismen som har beskrivits av ”det biologiska behovet att hjälpa”. Fem viktiga delar av omsorg och vård är kommunikation, empati, respekt, information och individens egna mål. Uppsatsen argumenterar att omsorg är viktigare än empati. Att empati borde omdefinieras så att den inte bara innebär att man vet vad patienten känner utan att man därmed investerar i patienten känslomässigt och motiveras att hjälpa. En viktig slutsats är att samverkan med patienten är nödvändig och att respekt för individens egna mål är av stor hjälp för den psykiatriska patienten som ofta är synnerligen utsatt i och med en ofta bristande självaktning.

Förord

I would like to thank all of the physiotherapists who took part in the interviews and made this thesis possible. I would also like to thank my supervisor, Torsten Norlander who, despite many ongoing projects, has spared time to provide guidance. A question that can easily arise as the reader goes through my essay is why I choose to focus on depression and not the alliance building as the title says. This is a conscious choice I have made in order to emphasize that the essay is mainly about how to build an alliance with an individual suffering from depression. During my 14 years as a physiotherapist working in psychiatric care, I have noticed that a patient suffering from depression needs more than any other patient category that a trusting alliance is built before any change becomes possible. This evoke often a lot of frustration and helplessness among physiotherapists.

Introduction

Depression is a condition that has existed for thousands of years and initially was called melancholy (Nemade, 2007). Since the Greeks and Romans had the belief that people with depressive symptoms were possessed by demons the treatment of depression was handled by priests. Greek historian Herodotus wrote 490 BC about a king who was possessed by demons and showed symptoms that strongly reminiscent of depression symptoms. Hippocrates, however, was the only historically known physician who gave depression a medical explanation. He believed the cause of depression be an imbalance of fluids in the body. He experimented some with the bile, adrenals and blood in order to find a cure for depression ((Nemade, Reiss Staats & Dombeck, 2007). Depression causes the sufferer a low self-esteem, loss of logical thinking, increased emotional thinking, increased irritability, increased tendency to isolation from the outside world, loss of appetite, insomnia, increased or decreased weight, absence of interests in things you before thought were enjoyable (Lane, 2013)

The Psychodynamic Approach. According to the psychodynamic approach, severe losses and other negative experiences in early childhood lead to the onset of depressive disorders in adulthood. People who have severe and psychologically stressful experiences in childhood appear to develop a personality that makes them more prone to depression in adulthood (Karlsson, 2004). According to Freud, who was founder of psychoanalysis, children who have received too much care and attention during the first year of life showed a greater tendency to develop depression later in adulthood. These children are used to get excess amount of affection and when they do not get as much during adult life, then they feel rejected and unwanted (Comer, 1992).

Biological perspective. According to psychiatrists who adopt a biological perspective, depression is caused by a lack of certain signal or transmitter substances in the central nervous system, or a reduced capacity to utilize these compounds (Schwartz & Schwartz, 1993). Examples of such substances are serotonin and norepinephrine. Not everyone who suffers from depression is found to be lacking these signal or transmitter substances. Some say that depression can be genetically inherited. According to the biological perspective, one should treat depression using antidepressants.

Social perspective. The social perspective focuses more likely on how the environment affects the body and mind rather than the biological aspects. According to this viewpoint, an increased level of social stressor and distress in one's life raises risk of suffering from depression.

Unemployment, immigration, economic conditions, social networks and social support are all examples of social factors that, if not satisfactory drastically increases the risk of depression (Hernandez, 2006).

Cognitive Analytical Therapy (CAT) perspective. The CAT perspective as proposed by Aaron Beck (1979) is perhaps the most accepted form of cognitive theory. Beck suggests that reduced affect in patients suffering from depressions is secondary to dysfunctional cognition. Three major features of cognition are believed to maintain the disorder. Firstly, the cognitive triad which consists of negative cognitions concerning three factors; oneself, the world and the future. Secondly we find faulty and defective thinking. Thirdly the depressed will use dysfunctional schema to perceive the world, Sometimes the cognitive perspective might seem as if it prizes only the higher intellectual functions and seem thus to devalue emotion, though a more nuanced version will see emotion as part of the evolved organism (Beck, 1979).

Physiotherapists involvement in psychiatric care has long been unknown, and for many unimportant. This trend started to change since several studies done in the fifties showed the positive effect of physical activity on the mental health. Physiotherapy has been used in psychiatry since the late 1960s, and physiotherapists today work with various treatments (Gyllensten, Nilsson, & Nilstun, 1993). In the treatment of depression basal body awareness is often used, breathing exercises, relaxation, soft tissue therapy, pain management and physical education. Physiotherapists in psychiatry meet patients with anxiety, depression, obsessive compulsive disorder, eating disorders, negative stress, self-destructive behavior, phobias, psychotic disorders and personality disorders. For the majority of these patients, depression is a part of their main diagnosis. It is well known that people with mental illness run an increased risk of developing depression (Broberg & Tynni-Lenné, 2010).

The depressed often feel a loss of energy and fatigue. Tasks that have before been a natural part of everyday life seem now to be impossible to manage. In a longitudinal study, the compliance of 74 patients with the treatments prescribed by their caregivers was followed up (Norcross, 2002). All patients showed a high number of cancellations and /or missed appointments. This study also showed that depressed patients have a tendency to choose treatments that require less physical effort. The establishment of a professional therapist-patient relationship is considered important in most medical situations (Forchuk & Reynolds, 2001). However, when the patient suffers from depression interpersonal interaction is the most important

part of the treatment (Cleary & Edwards, 1999). Although the therapeutic relationship is crucial for the outcome of treatment, the formation of an optimal alliance between therapist and patient is not an instinctive event but its establishment requires great skill (Moyle, 2003). Berg and Hallberg (2000) found that the care of people with depression "requires an intensified presence" in order not to lose them.

Purpose

The purpose of this study was to elucidate how physical therapists in the psychiatric field encounter patients with depression in order to create an optimal alliance.

Methods

Participants

The contents of this survey are based on material obtained from three physical therapists with experiences of working with patients with depression. Participants all work at Mölndal hospital's department of psychiatry and daily meet patients suffering from depression. Due to the limited number of psychiatric physiotherapists the criteria for inclusion covered all physiotherapists who agreed to participate in the study and were all professionally involved in the treatment of depressed patients. In Mölndal hospital's department of psychiatry four physiotherapists work, though one of these was on maternity leave during the period studied. The other three therapists agreed to participate in the study. The participants were all female and between 35 and 64 (average 49) years old, and had an experience ranging from 7 to 16 years in psychiatric health care. They had both formal and informal education in psychiatric physiotherapy.

Procedure

The physiotherapists were contacted by telephone and informed about the study. After showed interest in participating, further information about purpose of the study was given to participants during a personal meeting. Written information about the study was also given to them. Shortly after, the participants were contacted to schedule the interview. All informants had the opportunity before the interview to present their views and thoughts on the interview

questions. The informants have given their written consent to participate in the survey. Participation in the study was voluntary and could be discontinued at any time, during the interview, without giving any reason. The interview material was handled confidentially, transcribed verbatim and was read only by the interviewer (myself). The informants were interviewed individually. To follow up on the open questions and obtain a fuller description the interviewer repeated what was said and follow-up questions were asked. All this to ensure what the informants said had been understood correctly. The interviews lasted between 50-60 minutes. They were all recorded and later transcribed accurately by the interviewer.

Ethical considerations

The head of the current clinic was consulted about the design and implementation of the study. The informants received a request by mail to participate in the study, and then an oral statement by telephone where they were given the opportunity to ask questions. The interviewer reminded participants that participation was voluntary. They were asked to give written consent to participate and were informed that they could at any time opt out of the study with guaranteed confidentiality. Their data could only be used for this study and only the interviewer and the supervisor would have access to the material. Their personal data was decoded directly and each informant was given a number. Their names were not on tape recordings or in the transcribed material. In qualitative interview studies, the interviewer will often come closer to the informant than in quantitative studies. If any informant desired contact after the interview, this was offered by the interviewer. There were no treatment-related contacts between interviewer and the informants. A further ethical review was not considered necessary.

Data collection

Data were collected through qualitative, semi-structured interviews. An interview guide with some solid topics for discussion was used as support. The questions were openly worded and follow up questions were adapted to the responses of the participants. In order to establish contact, the interviews began with some general questions asking to the participants to briefly describe themselves, their background and current life situation. The interviews generated 3 hours of tape recording. In the transcription of data, such parts as the breaks, the coughs and other

noises were excluded. So were even some parts of the interviews that were not relevant to the purpose of the study.

Choice of analytical method

The material was transcribed and analyzed according to Giorgio's method which is a descriptive phenomenological method (Giorgi, 2009). Phenomenology focuses on the human consciousness and perceived experiences. The researcher makes efforts to get the individual to articulate her/his experiences into words. It therefore requires that the researcher immerses him or herself in the communicator's life-world and manages to get him or her to reflect his experience. The descriptive phenomenology is characterized by the phenomenological reduction (Giorgi, 2009). This means that the researcher liberate him or her or herself from their preconceptions and simply describes the phenomenon as it presents itself to his or her consciousness. The researcher should maintain a critical attitude to their own descriptions of the phenomenon, and thus prevent them getting mixed up with the data collected. The main objective of the survey is to obtain the essence of the phenomenon which is the essence of what we are investigating.

Analysis of data

Step1. Initially the interviews were written out word by word. Each interview was read through several times to enable a clear comprehension of the content.

Step 2. In the next stage, the content of each interview was divided into so-called Meaning Units (MU's). Cultural psychologist Carl Ratner describe meaning units as followed; *These are coherent and distinct meanings embedded within the protocol. They can be composed of any number of words. One word may constitute a meaning unit. Several sentences may also constitute a unit. A Meaning unit may contain a complex idea. It needs simply to be coherent and distinct from other ideas. The meaning unit must preserve the psychological integrity of the idea being expressed. It must neither fragment the idea into meaningless, truncated segments, nor confuse it with other ideas that express different themes (Ratner, 1997).*

In the analysis of the data, primarily concentrated on the MUs directly linked to the experience of creating an alliance with the patient at the first encounter. To illustrate how the analysis was performed an excerpt from an interview and a description on how the MUs were picked out of the protocol is shown: *"It is important not to push too much or do too much"*

"It is important to be aware of the fact that some do not want to be touched and do not like physical contact."

Step 3. In the third step the interview-language was translated to the phenomenological language. This means that, based on the interviewees' concrete language, I tried to interpret the sentence and extract the content of what is expressed. I strove to adopt a "phenomenological attitude" which implies that one has to free him or herself from preconceived ideas and strive for an openness in which the product should only be interpreted from its own content. The contents of each MU were interpreted in this way according to hermeneutical principles: the units were not interpreted separately, but on the basis of the whole (Kvale, 1983). With this style of interpretation, sometimes two seemingly different facts appear that superficially seem to have different meanings, but which prove to share the same psychological content. It may also be that the same fact has different meanings at different times and/or for different people (Karlsson, 1993). Below are MUs from an interview as an example of how an interpretation was made in this stage. Note that these are the same MUs used in the previous example, which are now interpreted to phenomenological language;

"It is important not to push too much or do too much."
"It is important to be aware of the fact that some do not want to be touched and do not like physical contact."
These two MUs describe various forms of situation that require a respectful attitude towards the patient. In the first example the interviewee explains the significance of showing respect for the patient's limited physical ability. In the second example the significance of showing respect for the patient's reluctance to be physically touched.

Step 4. In the fourth and final step MUs from the various interviews that were considered to have the same underlying content were subsumed under their common themes. This procedure identified one main theme with five aspects related to the experience of encountering patients that were presented in all interviews.

Results

The result is reported according to the theme emerged in the analysis of the interview material and is illustrated with quotes related to each aspect. The processing and analysis of the collected material resulted in 72 MU's out of the five different categories emerged. Each of these categories depicts an aspect of the studied phenomenon. These aspects interact with each other and highlight the essence of the phenomenon, which in this case is Caring. Below are mentioned some examples of the MU s for each category.

A caring approach

Caring refers both to an attitude - to care about - and to certain acts or activities – to take care of. Caring as attitude is related to interpersonal relations with patients, and between employees. In order to provide good care sensitivity, respect for the patients' needs and understanding of the patient's situation are all required. But a willingness to assist, to help and be able to help is also necessary (Norberg, Engström & Nilsson, 1994). Caring is often associated with compassion, care, flexibility, interest, commitment, love, education, presence, protection, participation, support, tenderness, affection and trust (Omvårdnadspolicy, 1997). To be validated is important for everybody. In case of illness, one is more in a need of care from others. The patient seeks help and comes to a caregiver to describe their experience and be treated. The psychiatric patient often does not recognize the signals from his/her body and needs to improve his/her self-esteem. The patient needs to be helped to recognize him or her-/herself in the midst of the disease - to regain or maintain his/her self-image.

Caring includes the relationships between caregiver and patient as well as the acts done to help, such as diagnosis, treatment, habilitation and rehabilitation. The concept of “caring” also includes a well-conceived health care philosophy and ethics, and an approach that involves treating the patient and his/her family as unique individuals with different needs and resources of a physical, mental, social and existential nature. A prerequisite for all of this is a safe care environment for patients, relatives and cargivers (Moyle, 2003). All physical therapists in the study emphatically confirmed that a caring attitude was the primary means of achieving an optimal alliance with the patient. Five different aspects of caring were detected, as described below.

Communication skills (12 MU's)

Communication has proved to be of great importance in the alliance process according to all the physiotherapists interviewed. The interviewees describe communication as a process that consists in giving and receiving messages, understanding what is meant, and having an awareness of verbal and nonverbal cues. It's not just a transfer of data but also a transfer of emotions, recognition of feelings, and a confirmation of the patient's feelings by the therapist. They believe that the development of communication skills means that the therapist becomes aware and acquires a broader understanding of what the patient wants to say. This is necessary for the therapist and the patient to achieve a common definition of the patient's situation and common understanding of what should be done.

”When communication works the patients are more satisfied with their care, more aware of how I define their problems and more cooperative.”

”I should not just listen to the patient's words but also interpret other signals like body language or behavior.”

Empathy (15 MU's)

Empathy is the ability to correctly discern another person's feelings and to convey this understanding to him or her. These skills can, according to the interviewed physiotherapists, help the therapist to truly understand the patient and provide reassurance to the patient. It was easier for physical therapists to feel empathy for the patient when an alliance has already been created over time and a deeper understanding of the patient has emerged.

”Having the ability to empathize with my patients' reactions creates alliances between me and them.”

“Empathy is the ability to perceive and understand other people's emotional states. If I lack this ability, I can never become a successful caregiver.”

“Psychiatric patients are often easily offended and this makes it more important to show empathy even by eye contact, adjusted tone and by showing a welcoming body language.”

Respect (16 MU's)

Another common aspect of care that all physiotherapists considered to be essential in each meeting with the patient is respect. According to them a good care requires sensitivity and respect for the patients' needs and understanding of the patient's situation. Two of the physiotherapists believed that a health care relationship involves respect for the patients' autonomy and a genuine belief in his/her ability to make his/her own choices and to act independently.

"If you push too hard, you can scare off the patient and give him or her/her low self-esteem."

"You have to both respect the patient's decisions and to strengthen and preserve the patient's decision-making capacity".

Information (22 MU's)

All the interviewed physiotherapists believe that the patient should be informed about her condition and about the methods of examination, treatment and available care. They tend to be clear when providing information and to not use long descriptions. One of the physiotherapists pointed out the importance of the patient receiving information in a way that she or he understands. One physiotherapist mentioned that information should not only be general, but must be based on the patient's situation, her/his needs for care and her circumstances. One physiotherapist emphasized the importance of informing the patient about confidentiality and telling him/her everything done in the treatment room is recorded in the patient's records. All the physical therapists try to avoid the beginner's mistake of making promises to the patient about the outcome of treatment. Two of the physiotherapists regularly inform the patient about pain and pain mechanisms. All the physical therapists inform patients about the physiotherapist's role in psychiatric care and how they work.

"I take into account the patient's low energy level and do not drown the patient with words when I provide information."

"The patient has a need to get information about her disease and learn what I can contribute to help her."

"I give the patient enough information about physical activity and its positive effect on depression."

Individual goals (7 MU's)

All therapists agreed that they must always, together with the patient, create a shared care plan in which the patient's personal goals are the starting point. According to two informants many therapists forget the patient's goals and propose treatment plans based on their own goals. All interviewees thought that the therapist must evaluate the patient's goals after a time and give feedback to the patient. At this stage it is sometimes necessary to set new goals. One physiotherapist believed that without a realistic goal formulated by the patient herself/himself the period of treatment could get long and cost-inefficient.

"treatment would be more efficient if it were mainly based on patient's knowledge and was based on patient's goals."

"To focus on the patient's own objectives and capture the patient's motivation is important for success in treatment."

"What kind of treatment is given depends in large extent on what symptom the patient first wants to get rid of."

Discussion

The purpose of this study was to illustrate how physiotherapists deal with the encounter with patients suffering from depression in order to achieve an optimal alliance. At the introduction to the survey the depressed patient's psychosomatic condition was under discussion as an issue that puts higher demands on the physical therapist to create a working alliance. Depressions can be of varying levels of difficulty and sometimes give severe symptoms. One of the most common symptoms that are debilitating to the depressed is lethargy and lack of motivation (Deborah Serani, 2011). All these factors limit the patient's ability to perceive information accurately and increase her irritability. These factors are some among many that make interactions with patients suffering from depression a difficult task that requires experience and knowledge. The analysis of this study resulted in a main theme "Demonstrate a caring approach" with five aspects. All the physiotherapists in this study believed strongly that a caring attitude was the primary way to achieve optimal alliance with the patient. Caring is a complex word with many aspects. Weiner (2007) describes caring as a long emotional commitment to a

person's well-being, shown by a willingness to take action that will lead to the improvement of person's overall mood.

There have been many studies in order to find evidence of whether care is learned or biological. Okasha (2002) describes in his research that altruism is a genetic need to help others. This altruism can be seen among many animals that have complex structures such as monkeys, bats and some social insect colonies such as ants, wasps, bees and termites. According to him, the aim of this altruism is to increase the chances of reproduction and thus survival. Caring is a complex word with many aspects. This qualitative study found five main aspects of this theme under discussion here that were identified both by consideration of the subject and by consideration of the literature studied. The first aspect was **communication** skill that according to all the interviewed physiotherapists was of great importance in the alliance process. The physiotherapists' experiences show patients value therapists who are patient centered and spend time and listen to them. Good therapist- patient communication has been shown to have a positive impact on a number of health outcomes in previous studies. In a research report (Titus Van Os, Van den Brink, Tiemens, Jenner, Van der Meer, & Ormel 2005), it was emphasized that "*In depressed patients, a good physician–patient relationship and good communication skills may be the first step to remove feelings of demoralization and isolation, restore hope, enhance motivation for treatment and enhance compliance".*

Moira Stewart and Judith Belle Brown concludes in their report the results of their analysis of 21 randomized studies examining the effect of physician-patient communication on the treatment outcome of the patient and how the success of the treatment effect will be. They could reveal that in all studies, the quality of communication in both history taking and discussion of treatment plan was directly related to treatment outcome (Stewart, 1995).

All these studies highlight the importance of communication skills and the role of a good therapist-patient relationship in buffering against patients' dissatisfaction with health services and complaints and in order to get a broader understanding of the patient´s need. Another aspect of a caring approach found in the study was **empathy**. The physiotherapists in general describe empathy as a form of emotional engagement, beneficial to patient care. Although usage varies, the term refers to sharing the feelings of another as a means of coming to a direct appreciation of the other. Defined this way, however, empathy may lead to mistaken assumptions and an absence

of corrective curiosity. Weiner and Auster (2007) define the interaction between empathy and caring as followed;

"Once we think we understand what another is experiencing, we perceive less need to ask, listen, and learn. We propose the process of "caring" in place of "empathy" to embody the ideal emotional and behavioral approach to patient care. Caring refers to both an emotional reaction to another and the expression of that reaction in action, independent of the sharing of the other's emotion or experience. The expression of caring in the clinical context is close observation, precise listening and responsive questioning, in concert with committed engagement and actions directly addressing the patient's problem, stripped of any assumptions about what the other might or might not be experiencing" (Weiner & Auster, 2007). It is assumed in the present paper that just because one has the ability to show empathy it does not necessarily mean that one cares for the patient. You may have empathy, yet be unmotivated to effectively help the patient in any way. Empathy means understanding how another person feels and guided by the understanding, make an emotional investment in the person by planning treatment according to the individual needs.

The third aspect of care that all physiotherapists considered to be essential in each meeting with the patient is **respect**. What mainly emerged from the interviews with the physiotherapists regarding this aspect was the respect that should be shown to the patient's ability to participate in the planning of her/his treatment. With this approach the patient's self-esteem grows which leads to stronger therapeutic alliance. Research shows that different patients have different views on participation and different needs to be involved (Frank, Asp & Dahlberg 2009). Some patients experience satisfaction with the care and treatment at the clinic even if they were passive and completely surrendered themselves to the staff (Wiman, Wikblad & Idvall 2006). Some patients feel involvement when staff observe their body language and offer help. In other cases, patients feel involved in their care only if they receive adequate information and advice. Some patients need to have space to feel satisfaction from their active participation in the process. This occurs when the therapist is sensitive to the patient's feelings, fears and anxieties. Regardless of the patient category, research shows that all patients need to feel respected and confirmed (Frank et al., 2009).

A fourth aspect of care found in this study is **information**. All the physiotherapists interviewed believe that the patient should be informed about her condition, the methods of

examination, treatment and available care. They tend to be clear when providing information and not use long descriptions. A report from the Danish National Board of Health in 2008 highlights the importance of adequate information between therapist and patient and how important it is to keep patients informed throughout the treatment process. According to the report, well-informed patients have better compliance, are more satisfied with treatment and respond better to treatment. This is partly because they perceive a greater control over the process (Jacobsen, Pedersen, & Albeck 2008).

The health policy analyst and director of global health services research unit Angela Coulter has followed the patient's satisfaction about the care they received in different state hospitals. Her follow-up study revealed that the most common dissatisfaction among patients in general "is not feeling properly informed (and involved in) about their treatment". She also emphasizes that the two factors, age and cultural background play an important role in what extent the patient ask for information (Angela Coulter & Suzanne Parsobs & Janet Askham 2008). Two of the physiotherapists often inform the patient about pain and pain mechanisms. Pain and its consequences are one of the most common reasons for seeking medical care in Sweden today. Around 20 % of the Swedish population has chronic pain problems that cause difficulties in everyday life. The International Organization for the Study of Pain (IASP) has agreed to define pain as an unpleasant sensory and emotional experience associated with tissue damage or impending tissue damage or described in terms of such damage. Pain is associated with emotional and psychological reactions and is an experience that cannot be measured objectively. So it is a condition that affects the whole individual and it's surrounding and must be taken seriously (SBU, 2006).

A fifth aspect of care in this study is the individual's goal. All the physical therapists agreed that they must always, together with the patient, create a shared care plan in which the patient's own wishes and personal goals are the starting point. It is important to consider the individual patient's capacity to achieve a treatment goal. The goals that are set can be both short and long term goals. They must be realistic, achievable and evaluable, and they may sometimes need to be adjusted over time (Eiseer & Gentle, 1988). According to two informants many physical therapists forget the patient´s goal and propose treatment plan based on their own goals. A common mistake in health care is the fact that many therapists are used to ingrained treatment patterns, which they believe, are suitable for all patients suffering from depression. They do not

realize that even patients with the same diagnosis may have completely different needs and potentials. A physical therapist with this idea often suggests the patient a complete treatment program and believes this to be the optimal help. It is not surprising then if the patient quickly gives up and drops out of treatment (Schoeb, 2009).

All interviewees thought that the therapist must evaluate the patient´s goals after a time and give realistic feedback. At this stage it is sometimes necessary to set new goals. Patients appreciate the active response such as suggestions, constructive criticism, feedback, hope and encouragement. This need is stronger the less confidence the patient has. Patients with mental illness often suffer from poor self-esteem and therefore need more encouragement and positive feedback (Shattel, Mclister, Hogan & Thomas 2006).

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